

STATE OF ILLINOIS

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Facility Name & ID Number Aviston Countryside Manor# 0033407 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>63</u>	Intermediate (ICF)	<u>63</u>	<u>22,995</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>877</u>	<u>147</u>	<u>3,605</u>	<u>4,629</u>	8
9	SNF/PED					9
10	ICF	<u>14,304</u>	<u>10,530</u>		<u>24,834</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,181</u>	<u>10,677</u>	<u>3,605</u>	<u>29,463</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.22%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 02/23/1988

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 16 and days of care provided 3,605Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Aviston Countryside Manor

0033407

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	119,819	9,446	6,285	135,550		135,550		135,550			1
2	Food Purchase		136,682		136,682		136,682	(7,433)	129,249			2
3	Housekeeping	78,819	14,358		93,177		93,177	130	93,307			3
4	Laundry	66,690	12,594		79,284		79,284		79,284			4
5	Heat and Other Utilities			70,638	70,638		70,638	922	71,560			5
6	Maintenance	30,815	62,343	314	93,472		93,472	15,820	109,292			6
7	Other (specify):* Sanitation			7,010	7,010		7,010		7,010			7
8	TOTAL General Services	296,143	235,423	84,247	615,813		615,813	9,439	625,252			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,001,510	54,713	8,975	1,065,198		1,065,198		1,065,198			10
10a	Therapy			504,912	504,912		504,912		504,912			10a
11	Activities	37,413	5,028	1,682	44,123		44,123		44,123			11
12	Social Services	27,437			27,437		27,437		27,437			12
13	Nurse Aide Training			1,931	1,931	(185)	1,746		1,746			13
14	Program Transportation		2,455		2,455		2,455		2,455			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,066,360	62,196	519,900	1,648,456	(185)	1,648,271		1,648,271			16
	C. General Administration											
17	Administrative	101,568	8,983	205,000	315,551	(2,773)	312,778	(138,847)	173,931			17
18	Directors Fees											18
19	Professional Services			12,790	12,790		12,790	1,991	14,781			19
20	Dues, Fees, Subscriptions & Promotions			9,629	9,629	1,064	10,693	(5,000)	5,693			20
21	Clerical & General Office Expenses	18,968	15,806	12,615	47,389		47,389	45,711	93,100			21
22	Employee Benefits & Payroll Taxes			217,387	217,387	688	218,075	13,643	231,718			22
23	Inservice Training & Education					785	785		785			23
24	Travel and Seminar			1,849	1,849	421	2,270		2,270			24
25	Other Admin. Staff Transportation							1,052	1,052			25
26	Insurance-Prop.Liab.Malpractice			58,989	58,989		58,989	2,320	61,309			26
27	Other (specify):*											27
28	TOTAL General Administration	120,536	24,789	518,259	663,584	185	663,769	(79,130)	584,639			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,483,039	322,408	1,122,406	2,927,853		2,927,853	(69,691)	2,858,162			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Aviston Countryside Manor

#0033407

Report Period Beginning:

01/01/2003

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			107,353	107,353		107,353	7,136	114,489			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			23,245	23,245		23,245	674	23,919			33
34	Rent-Facility & Grounds			6,000	6,000		6,000	(6,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			136,598	136,598		136,598	1,810	138,408			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,437	16,507	105,944		105,944		105,944			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,107	53,107		53,107		53,107			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		89,437	69,614	159,051		159,051		159,051			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,483,039	411,845	1,328,618	3,223,502		3,223,502	(67,881)	3,155,621			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Countryside Manor

0033407

Report Period Beginning:

01/01/2003

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12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(653)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,282)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(1,172)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,506)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(392)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,469)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	808	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (13,666)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(54,215)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (54,215)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (67,881)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Aviston Countryside Manor

ID# 0033407

Report Period Beginning: 01/01/2003

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Adjust for deferred maintenance	\$ 1,108	6	1
2	Vending machine cost	(4,498)	2	2
3	2004 Computer Maintenance paid in 2003	(2,373)	6	3
4	Record 2003 IHCA Dues	3,660	20	4
5	Staight Line Depr on items required to be capitalized	3,328	30	5
6	Offset rebate	(200)	21	6
7	Offset refund	(217)	26	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	808		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aviston Countryside Manor

0033407

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,433)	0	0	0	0	0	0	0	0	0	0	(7,433)	2
3	Housekeeping	0	130	0	0	0	0	0	0	0	0	0	130	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	922	0	0	0	0	0	0	0	0	0	922	5
6	Maintenance	(1,265)	17,085	0	0	0	0	0	0	0	0	0	15,820	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,698)	18,137	0	0	0	0	0	0	0	0	0	9,439	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(138,847)	0	0	0	0	0	0	0	0	0	(138,847)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,506)	3,497	0	0	0	0	0	0	0	0	0	1,991	19
20	Fees, Subscriptions & Promotions	(5,201)	201	0	0	0	0	0	0	0	0	0	(5,000)	20
21	Clerical & General Office Expenses	(200)	45,911	0	0	0	0	0	0	0	0	0	45,711	21
22	Employee Benefits & Payroll Taxes	0	13,643	0	0	0	0	0	0	0	0	0	13,643	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	1,052	0	0	0	0	0	0	0	0	0	1,052	25
26	Insurance-Prop.Liab.Malpractice	(217)	2,537	0	0	0	0	0	0	0	0	0	2,320	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,124)	(72,006)	0	0	0	0	0	0	0	0	0	(79,130)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,822)	(53,869)	0	0	0	0	0	0	0	0	0	(69,691)	29

Summary B

12/31/2003

12/31/2003

[illegible]

Facility Name & ID Number Aviston Countryside Manor# 0033407Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00	Mt. Vernon Countryside Manor, Inc.	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00	Taylorville Care Center, Inc.	Taylorville			
Jerry & Marilyn King	100.00	Golden Manor Nursing Home, Inc.	Nokomis			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	3 See Schedule VIII	\$	King Management Co.	100.00%	\$ 130	\$ 130 1
2	V	5 See Schedule VIII		King Management Co.	100.00%	922	922 2
3	V	6 See Schedule VIII		King Management Co.	100.00%	17,085	17,085 3
4	V	17 See Schedule VIII	205,000	King Management Co.	100.00%	66,153	(138,847) 4
5	V	19 See Schedule VIII		King Management Co.	100.00%	3,497	3,497 5
6	V	20 See Schedule VIII		King Management Co.	100.00%	201	201 6
7	V	21 See Schedule VIII		King Management Co.	100.00%	45,911	45,911 7
8	V	22 See Schedule VIII		King Management Co.	100.00%	13,643	13,643 8
9	V	25 See Schedule VIII		King Management Co.	100.00%	1,052	1,052 9
10	V	26 See Schedule VIII		King Management Co.	100.00%	2,537	2,537 10
11	V	30 See Schedule VIII		King Management Co.	100.00%	4,980	4,980 11
12	V	33 See Schedule VIII		King Management Co.	100.00%	674	674 12
13	V	34 Land Lease	6,000	Jerry King	100.00%		(6,000) 13
14	Total		\$ 211,000			\$ 156,785	\$ * (54,215) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Aviston Countryside Manor # 0033407 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00	57,100	15	24.67%	Salary	\$ 18,699	17,8	1
2	Denise King	Regional Director	Administrative	0.00	133,134	15	24.67%	Salary	43,599	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	44,412	12	24.67%	Salary	14,544	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	0	40	100%	Salary	99,564	17,1	4
5	Elizabeth King	Dietary	Dietary	0.00	0	8	100%	Salary	2,496	1,1	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00	3,013	1	24.67%	Salary	987	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 179,889		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Countryside Manor# 0033407

Report Period Beginning:

01/01/2003Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization King Management CompanyStreet Address 935 South Mill StreetCity / State / Zip Code Nashville, IL 62263Phone Number (618) 327-3064Fax Number (618) 327-3083

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	119,399	4	\$ 525	\$ 29,455	\$ 130	1
2	5	Utilities	Patient Days	119,399	4	3,738	29,455	922	2
3	6	Maintenance	Patient Days	119,399	4	69,255	58,956	29,455	17,085
4	17	Administrative	Patient Days	119,399	4	268,160	256,531	29,455	66,153
5	19	Professional Fees	Patient Days	119,399	4	14,175	29,455	29,455	3,497
6	20	Dues, Fees & Subscriptions	Patient Days	119,399	4	813	29,455	201	6
7	21	Clerical and Office Expense	Patient Days	119,399	4	186,105	131,685	29,455	45,911
8	22	Employee Benefits	Patient Days	119,399	4	55,304	29,455	29,455	13,643
9	25	Other Admin. Staff Transport	Patient Days	119,399	4	4,263	29,455	29,455	1,052
10	26	Insurance	Patient Days	119,399	4	10,283	29,455	29,455	2,537
11	30	Depreciation-Other	Patient Days	119,399	4	11,457	29,455	29,455	2,826
12	30	Depreciation-Vehicles	Patient Days	119,399	4	8,733	29,455	29,455	2,154
13	30	Depreciation-Copiers	Direct Cost	1	1	679	0	0	13
14	33	Real Estate Taxes	Patient Days	119,399	4	2,732	29,455	674	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 636,222	\$ 447,697	\$ 156,785	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Schedule Not Applicable						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Aviston Countryside Manor**# **0033407** Report Period Beginning: **01/01/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ 25,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 23,645	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (1,555)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 24,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 23,245	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 23,871 8	FOR OHF USE ONLY	
	1999 23,663 9		
	2000 23,658 10	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
	2001 23,998 11		
	2002 23,645 12	14	PLUS APPEAL COST FROM LINE 5 \$ 14
Line 2: Real Estate Tax Payment was for 2002 tax year.	Line 7: \$23,245 Real Estate Tax	15	LESS REFUND FROM LINE 6 \$ 15
Line 4: Accrual is based on 2002 taxes paid.	674 Home Office Allocation	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
	\$23,919 Total Real Estate Tax		

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aviston Countryside Manor COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0033407

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-05-24-105-007</u>	<u>Sec 24 Twp 2 Rng 5 PT SW NW 2.77±</u>	\$ <u>23,135.16</u>	\$ <u>23,135.16</u>
2. <u>05-05-24-105-018</u>	<u>Sec 24 Twp 2 Rng 5 PT SW NW .63A</u>	\$ <u>234.38</u>	\$ <u>234.38</u>
3. <u>05-05-24-105-005</u>	<u>Sec 24 Twp 2 Rng 5 PT SW NW .57A</u>	\$ <u>275.34</u>	\$ <u>275.34</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>23,644.88</u></u>	\$ <u><u>23,644.88</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet: 28,617
 B. General Construction Type:

Exterior Brick
 Frame _____

 Number of Stories One

C. Does the Operating Entity?

☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
Section Not Applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

 If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building & Parking Lot	108,900	1986	\$ 44,774	1
2	Home Office			1,552	2
3	TOTALS	108,900		\$ 46,326	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Countryside Manor

0033407

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	70	1988	1988	\$ 1,472,741	\$ 48,046	30	\$ 49,091	\$ 1,045	\$ 777,279
5		1988	1988	66,310	2,210	30	2,210		41,259
6	27	1990	1990	352,911	13,097	30	11,764	(1,333)	159,791
7		1990	1990	6,649	227	30	222	(5)	3,020
8									
Improvement Type**									
9	Level & Remove Dirt	1988		1,428		10			1,428
10	Landscaping & Sod	1988		4,046		10			4,046
11	Shrubs	1988		1,219		10			1,219
12	Patio	1988		20,500	1,025	20	1,025		16,058
13	Parking Lot	1988		37,691	1,885	20	1,885		29,839
14	Landscaping	1988		1,900		10			1,900
15	Sidewalk and Patio	1988		1,161	58	20	58		919
16	Landscaping	1988		1,020	51	20	51		782
17	Doors/Door Frames	1988		16,064	803	20	803		12,717
18	Finishing Work on Additions	1990		918		15	61	61	800
19	Storage Building	1993		3,900	260	15	260		2,752
20	Water Heater	1994		3,164	211	15	211		1,969
21	Electrical Work	1994		2,293	229	10	229		2,273
22	Flooring	1995		9,255	926	10	926		8,238
23	Asphalt Parking Lot	1995		8,288	829	10	829		7,045
24	Double Detector Check Valve	1995		1,750	175	10	175		1,415
25	HVAC-Kitchen/Laundry	1996		14,577	857	17	857		6,359
26	Water Heater	1996		3,312	221	15	221		1,767
27	Hot Water Heater	1997		3,802	253	15	253		1,626
28	Landscaping	1997		3,499	350	10	350		2,246
29	Vinyl Flooring	1997		2,570	257	10	257		1,606
30	Floor Tiles	1997		3,525	353	10	353		2,174
31	Water Heater	1999		3,468	347	15	231	(116)	963
32	Wallcovering/Flooring	1999		1,774	177	10	177		724
33	Carpet	1999		12,873	1,287	10	1,287		5,256
34	Window Treatments	1999		7,734	773	5	1,547	774	7,348
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Aviston Countryside Manor

0033407

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Renovation C-wing	2000	\$ 6,749	\$ 450	15	\$ 450		\$ 1,612		37
38	Wallpaper	2000	7,178	1,436	5	1,436		5,025		38
39	Paint	2000	1,745	349	5	349		1,367		39
40	Dressers and Installation	2000	3,870	258	15	258		989		40
41	Countertops and Installation	2000	4,008	200	20	200		768		41
42	Tile	2000	1,857	186	10	186		573		42
43	Window Treatments	2000	3,049	610	5	610		2,287		43
44	Wanderguard System	2000	2,102	210	10	210		753		44
45	Room Doors	2000	2,699	270	10	270		922		45
46	Tile	2000	2,515	252	10	252		755		46
47	Gravel Parking Lot	2001	2,698		5	539	539	1,933		47
48	3 Air Conditioner Units	2001	1,770		5	354	354	1,180		48
49	Tile	2001	2,602		10	260	260	802		49
50	Diamond Retaining Wall	2001	1,980	198	10	198		528		50
51	Cabinets	2001	23,546	2,355	10	2,355		6,476		51
52	Addition to Fire Alarm System	2001	4,368	437	10	437		1,165		52
53	Electrical Repairs to Service Entrance	2001	6,725	673	10	673		1,906		53
54	Carpet	2001	3,051	305	10	305		915		54
55	Door Security System	2001	10,589	1,059	10	1,059		2,294		55
56	Water Heater	2002	4,552	303	15	303		505		56
57	3 Rooftop A/C Units	2002	14,243	1,424	10	1,424		1,661		57
58	Phone System	2002	7,344	734	10	734		795		58
59	Dinning Room Addition	2003	8,600	108	40	108		108		59
60	Parking Lot	2003	5,446	182	10	182		182		60
61	Landscaping	2003	3,040	101	10	101		101		61
62										62
63	Home Office Parking Lot	1989	488					488		63
64	Home Office Building	1995	24,183		25	967	967	7,900		64
65	Home Office Interior Finishes Lower Level	1996	1,500		15	100	100	750		65
66	Home Office Carpet	1996	524		5			524		66
67	Home Office Cabinets	1996	830		20	41	41	311		67
68	Home Office Electrical	1996	287		15	19	19	144		68
69	Home Office Front Door	2002	395		10	39	39	49		69
70	TOTAL (lines 4 thru 69)		\$ 2,234,875	\$ 87,007		\$ 89,752	\$ 2,745	\$ 1,150,586		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 179,331	\$ 14,322	\$ 17,251	\$ 2,929	5-15	\$ 117,712	71
72	Current Year Purchases	39,006	4,007	4,486	479	5	4,486	72
73	Fully Depreciated Assets	403,661					403,661	73
74								74
75	TOTALS	\$ 621,998	\$ 18,329	\$ 21,737	\$ 3,408		\$ 525,859	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1998 Ford E350 Van	1999	\$ 20,298	\$ 846	\$ 846		4	\$ 20,298	76
77	Home Office Vehicle	2002 Ford F150 Truck	2002	3,500		875	875	4	1,458	77
78	Home Office Vehicle	2004 Lexus RX 330	2003	10,236		1,279	1,279	4	1,279	78
79										79
80	TOTALS			\$ 34,034	\$ 846	\$ 3,000	\$ 2,154		\$ 23,035	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,937,233	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,182	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,489	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,307	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,699,480	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Outbuilding	\$ 17,573	\$ 1,171	\$ 8,689	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 17,573	\$ 1,171	\$ 8,689	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ N/A YES ☒ N/A NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input checked="" type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	580	1,166		1,746
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 580	\$ 1,166	\$	\$ 1,746
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,746			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	6

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	10,131	\$ 193,082	\$	10,131	\$ 193,082	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		3,511	93,379		3,511	93,379	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		11,051	218,452		11,051	218,452	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				89,437		89,437	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-Ray	39,3				16,507			16,507	13
14	TOTAL			\$	24,693	\$ 521,420	\$ 89,437	24,693	\$ 610,857	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Aviston Countryside Manor

0033407

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 432,924	\$	1
2	Cash-Patient Deposits	1,706		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,106)	590,456		3
4	Supply Inventory (priced at)	5,150		4
5	Short-Term Investments			5
6	Prepaid Insurance	58,785		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,089,021	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,225,059		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	600,220		16
17	Accumulated Depreciation (book methods)	(1,647,927)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	5,798		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,798)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,177,352	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,266,373	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 181,216	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,706		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,853		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,917		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	2,057		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 368,549	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 368,549	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,897,824	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,266,373	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,802,912	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,802,912	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	570,253	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(466,936)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Prior Year IL Replacement Tax Adj.	(8,405)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 94,912	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,897,824	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,371,681	1
2	Discounts and Allowances for all Levels	(356,660)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,015,021	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	756,358	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 756,358	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,075	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,897	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,972	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	305	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 305	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	9,067	28
28a	Diaper Charges	32	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,099	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,793,755	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	615,813	31
32	Health Care	1,648,456	32
33	General Administration	663,584	33
	B. Capital Expense		
34	Ownership	136,598	34
	C. Ancillary Expense		
35	Special Cost Centers	105,944	35
36	Provider Participation Fee	53,107	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,223,502	40
41	Income before Income Taxes (line 30 minus line 40)**	570,253	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 570,253	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Aviston Countryside Manor# 0033407Report Period Beginning: 01/01/2003Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,894	2,119	\$ 46,798	\$ 22.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,377	14,534	263,130	18.10	3
4	Licensed Practical Nurses	9,748	10,828	160,664	14.84	4
5	Nurse Aides & Orderlies	55,822	57,657	504,809	8.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,857	5,227	37,413	7.16	10
11	Social Service Workers	3,113	3,376	27,437	8.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,786	16,625	119,819	7.21	15
16	Dishwashers					16
17	Maintenance Workers	2,030	2,153	30,815	14.31	17
18	Housekeepers	10,191	10,711	78,819	7.36	18
19	Laundry	8,526	9,107	66,690	7.32	19
20	Administrator	2,089	2,034	101,568	49.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,932	2,093	18,968	9.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,269	2,529	26,109	10.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,634	138,993	\$ 1,483,039 *	\$ 10.67	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	131	\$ 5,655	1,3	35
36	Medical Director	Contract	2,400	9,3	36
37	Medical Records Consultant	12	688	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,200	10,3	39
40	Physical Therapy Consultant	142	7,087	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,682	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	315	\$ 18,712		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ Section N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Wallpaper	4/01	\$ 3,323		\$	\$ 831	\$ 1,108	\$ 1,108	\$ 276	\$	\$	\$	\$
2													
3													
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19													
20	TOTALS		\$ 3,323		\$	\$ 831	\$ 1,108	\$ 1,108	\$ 276	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Aviston Countryside Manor**

STATE OF ILLINOIS

0033407

Report Period Beginning: **01/01/2003**

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Ending: **12/31/2003**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc. - \$3,660
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,667 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,107
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A - None Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 62%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

AVISTON COUNTRYSIDE MANOR, INC.
IDPH ID #0033407
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/03

OTHER REVENUE:

VENDING INCOME	\$6,716
REFUNDS & REIMBURSEMENTS	1,070
INTEREST	48
MISCELLANEOUS	163
MEDICARE COST REPORT SETTLEMENT	933
A/R ADJUSTMENTS	137
	<u>9,067</u>